CONSENT FOR TWO-STAGE OSSEOUSINTEGRATED IMPLANT WITH SINUS-LIFT/BONE GRAFTING PROCEDURE

Patient’s Name: ______________________________ Date: ________

You have the right to be given information about your proposed implant placement so that you are able to make the decision as to whether to proceed with surgery. What you are being asked to sign is confirmation that you have been given information on the nature of your proposed treatment, the known risks associated with it and the possible alternative treatments.

1. Dr. Shah has informed me of my diagnosis (condition) which is described as:

2. The surgical procedure proposed to treat the above condition has been explained to me and I understand it to be:

3. I understand that incisions will be placed inside my mouth in the upper jaw for the purpose of placing one or more endosteal root form structures (implants) in my jaw to serve as anchors for a missing tooth or teeth replacement or to stabilize a crown (cap), bridge or denture. I acknowledge that the doctor has explained the procedure, including the number and location of incisions and the type of implant to be used. I also understand that the crown, bridge or denture that will later be attached to this implant(s) will be made and attached by Dr. and that a separate charge will be made by that office.

4. In my case, I further understand that there is not enough natural jawbone in which to place the proposed implant and that a procedure called “sinus lift” is planned. This procedure is more complicated than usual implant placement and involves opening the sinus cavity in my upper jaw and placing a bone graft in order to provide support for the implant. I have been told that this graft could come from specially-prepared donated bone, or may be taken from my jaw, chin, skull or hip, any of which might be supplemented with specially-prepared donated bone or bone substitute. I understand that if donated bone is used, I will NOT be able to donate blood or transplant organs for 1 year, 365 days from my surgery.

5. I understand the implant(s) must remain covered by gum tissue for at least six months or longer, before it can be used, and that a second surgical procedure is required to uncover the top of the implant(s). No guarantee can be or has been given that the implant(s) will last for a specific time period. It has been explained to me that once the implant(s) is/are inserted, the entire treatment plan must be followed and completed on schedule. If this is not done, the implant(s) may fail.

CONSENT FOR TWO-STAGE OSSEOUSINTEGRATED IMPLANT WITH SINUSLIFT/BONE GRAFTING PROCEDURE

6. I have been informed of possible alternative forms of treatment (if any), including: I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me.

Initial _____
7. My doctor has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance such risks include, but are not limited to, the following:

**RISKS OF IMPLANT SURGERY**

A. Post-operative discomfort and swelling that may require several days of at home recuperation.

B. Prolonged or heavy bleeding that may require additional treatment, because the sinus is involved, some bleeding may be from the nose.

C. Injury or damage to adjacent teeth or roots of adjacent teeth, possibly requiring further root canal therapy, and occasionally the loss of an injured tooth.

D. Post-operative infection, including sinus infection, that may require additional treatment. In rare instances an opening may develop between mouth and sinus, again requiring additional treatment.

E. Stretching of the corners of the mouth that may cause cracking and bruising.

F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ).

G. Possible prolonged symptoms of sinusitis requiring certain medications and longer recovery time, resulting from intentional entry into the sinus.

H. Fracture of the jaw.

I. Possible injury to nerve branches in the bone resulting in numbness, pain or tingling of the lips, cheek, gums or teeth. If implants are placed in the lower jaw, there may be numbness or pain of the chin or tongue also. These symptoms may persist for several weeks, months or, in rare instances, may be permanent.

**GENERAL RISKS OF BONE GRAFTING**

A. Bleeding, swelling or infection at the donor site requiring further treatment.

B. Allergic or other adverse reaction to drugs used during or after the procedure.

C. The need for additional or more extensive procedures in order to obtain sufficient bone for grafting.

**RISKS AND COMPLICATIONS OF GRAFTING FROM WITHIN THE MOUTH AREA**

A. Damage to adjacent teeth, which may require future root canal procedures, or may cause loss of those teeth.

B. Removal of adult teeth in order to obtain sufficient bone material.

C. Numbness or pain in the area of the donor or recipient site, or more extensive areas, which may be temporary or permanent.
D. Penetration of the sinus or nasal cavity in the upper jaw which could result in infection or other complication requiring additional drug or surgical treatment.

RISKS AND COMPLICATIONS OF BONE GRAFTING FROM THE HIP REGION

A. Numbness, burning and/or pain of the hip, thigh or buttocks which may be temporary or permanent.
B. Gait disturbance - inability to walk normally - which may be temporary or permanent.
C. Hematoma requiring further treatment and hospitalization.
D. Perforation into the abdomen requiring further treatment and hospitalization.
E. Sciatica - radiating pain to the legs from irritation of the sciatic nerve, possibly persistent.
F. Unsightly scarring at the incision site which may be permanent despite later revision.

RISKS AND COMPLICATIONS OF BONE GRAFTING FROM THE SKULL

A. Shaving of hair from portions of the scalp which may grow in differently from surrounding hair.
B. Scars from the incisions which may become more noticeable with hair loss in later life.
C. Numbness of certain areas of the scalp which may be temporary or permanent.
D. Decreased function of certain muscles of facial expression, notably an inability to furrow the brow or raise the eyebrows normally, either temporary or permanent.
E. Wound infection or breakdown requiring further treatment.
F. Bleeding of scalp or deeper vessels that may require further treatment.
G. Subdural hematoma, cerebrospinal fluid leak, meningitis or damage to membranes surrounding the brain that may have neurologic consequences and may require further care by a specialist and hospitalization.
H. Contour abnormalities or bony irregularities of the skull that, although hidden by hair, may have cosmetic effects.

RISKS OF FREEZE-DRIED, DEMINERALIZED OR OTHER BANKED BONE

On occasion, additional donated bone is used to supplement the patient’s bone, or to spare an extensive donor site surgical procedure. Use of such bone may involve separate risks including, but not limited to:

A. Rejection of the donated graft material together with the entire graft.
B. The remote chance of disease transmission from processed bone.

8. I understand that in my grafting procedure, the use of (autogenous, demineralized, etc.) bone is expected to be taken from (note anatomic area), plus(other area)
9. ANESTHESIA

The anesthesia I have chosen for my surgery is:

- Local Anesthesia
- Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
- Local Anesthesia with Oral Premedication
- Local Anesthesia with Intravenous Sedation
- General Anesthesia

10. ANESTHETIC RISKS include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability, and may require special care. Nausea and vomiting, although rare, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

11. YOUR OBLIGATIONS IF IV ANESTHESIA IS USED

A. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are recovered sufficiently to care for yourself. This may be up to 24 hours.

B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFETHREATENING!

D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, using only a small sip of water.

12. It has been explained to me that in the course of the procedure unforeseen conditions may be revealed which will necessitate extension of the original procedure, a different procedure from those set forth above, or abandonment of the procedure entirely. In such an event, I authorize my doctor and his staff to perform such procedures as are necessary and desirable in the exercise of professional judgment to complete my surgery.

13. I understand that my doctor is not a seller of the implant device itself and makes no warranty or guarantee regarding success or failure of the implant or its attachments used in the procedure.

Initial _____
14. I understand smoking is extremely detrimental to the success of implant surgery. I agree to cease all use of tobacco for 2-3 weeks prior to and after surgery, including the later uncovering procedure, and to make strong efforts to give up smoking entirely.

15. It has been explained to me and I understand that a perfect result is not, and cannot be guaranteed or warranted.

CONSENT

I certify that I speak, read and write English and have read and fully understand this consent for surgery, and that all blanks were filled in prior to my initialing and signing this form and that all my questions were answered to my satisfaction.

Patient’s (or Legal Guardian’s) Signature: ________________________________
Date: __________________

Doctor’s Signature: __________________________ Date: ______________

Witness’ Signature: __________________________ Date: ______________
BIOPSY AND SOFT TISSUE CONSENT FORM

For:

SECTION I. Patient Information

1. I hereby authorize and direct Dr. Shah and assistants of his/her choice to perform the following operation(s) or procedure(s):_____________________________

2. I hereby authorize and direct the above named surgeon or other physician and/or associates and assistants to provide or arrange for the provision of such additional services or related procedures that are deemed necessary or advisable, including, but not limited to, pathology and radiology services.

3. All operations and procedures may involve risks of unsuccessful results, complications, injury, or even death, from known and unforeseen causes. You have the right to be informed of such risks, as well as the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, and the available alternative methods of treatment and their risks and benefits. You also have the right to be informed as to whether your physician has any independent medical research or economic interests related to the performance of the proposed operation or procedure. Except in cases of emergency, you have the right to receive this information and to give your consent before operations or procedures are performed. You have the right to consent to or to refuse any proposed operation or procedure at any time prior to its performance. No warranty or guarantee is made as to the result or cure.

4. Your signature below confirms that you authorize the pathologist to use his or her discretion in the disposition or use of any member, organ, or other tissue removed from your person during the operation or procedure identified above.

Your signature on this form indicated: (1) You have read and understood the information contained herein; (2) You have been verbally informed about this operation or procedure; (3) You have had the opportunity to ask questions regarding this operation or procedure; (4) You have received all of the information you desire; and (5) you authorize and consent to the performance of the operation or procedure.

Signature of Patient __________________________________________________
Date Time_________________________________________________

Signature of Witness _____________________________________ 
Date Time __________________________________________________

Your signature below indicates that: (1) You have read discussed the risks, benefits, and options of anesthesia (as listed on back of form) with a representative of the anesthesia department; (2) You have received answers to all of your questions; and (3) You authorize and consent to the anesthesia plan discussed.

Signature of Patient __________________________________________________
Date Time_________________________________________________

Signature of Witness _____________________________________ 
Date Time __________________________________________________

SECTION II. Patient Declines to be Informed

Initial _____
Although I have been given an opportunity to be advised as to the nature and purpose of the operation or procedure, and the risks, benefits, and alternatives, I specifically decline to be so advised, but I do give my consent to the operation. No warranty or guarantee has been made as to the result or cure.

Signature of Patient ____________________________________________
Date Time_____________________________________________________

Signature of Witness ____________________________________________
Date Time_____________________________________________________

Initial _____
BLOCK GRAFT CONSENT FORM

For:

DX: Insufficient available bone in the __________________________________________________
part of my upper/lower jaw, front and/or back.

PROCEDURE: Taking a block of bone from the back of my lower jaw or the front (chin) of my lower
jaw or the front (chin) of my lower jaw and placement of this graft of
_________________________________.

ANESTHESIA: TOPICAL LOCAL PO SEDATION- N2O/02

IV SEDATION GENERAL

Dr. Shah has extensively discussed the proposed surgery noted above, including the expected benefits and
the alternatives to treatment, if any. I have also been advised of the associated potential risks and possible
complications of the proposed procedures including, but not limited to: reaction or allergy to medications,
bleeding, infection, swelling, pain, bruising, limited opening, jaw joint (TMJ) pain/dysfunction,
involvement of the maxillary sinus, damage to other teeth or dental work, alveolar osteitis (dry socket or
loss of the clot formed in the extracted tooth socket requiring treatment by irrigation and dressing
placement), numbness of the tongue, lips, or face, nausea/vomiting, unplanned laceration, tear, burn, or
abrasion of intraoral mucosa or skin with the need for additional treatment or surgical repair, and the
possibility of the need for other surgery or hospitalization.

I understand that if the planned procedure is performed by laser, a risk of burns to mucosa,
skin, or eyes could exist. If I am to receive medicines to relax me (IV sedation/general anesthesia, nitrous
oxide/oxygen analgesia or oral sedative pre-med), I have been advised of the additional risks and possible
complications, i.e., nausea, vomiting, an allergic or unexpected reaction (if severe. allergic reactions
might cause more serious respiratory (lung) or cardiovascular (heart) problems which may require
treatment). In addition, there may be: pain, swelling, inflammation or infection of the area of the
injection, injury to nerves or blood vessels in the area, disorientation, confusion, or prolonged drowsiness
after surgery, cardiovascular or respiratory responses which could lead to heart attack, stroke, or death.
Fortunately, these complications and side effects are not common. Well-monitored anesthesia is generally
very safe, comfortable, and well-tolerated. If you have any questions, PLEASE
ASK.

I understand I am to:

Have nothing to eat or drink 8 hours prior to surgery. Have an escort, who is a responsible adult, drive
me to the appointment, stay in the waiting room, and drive me home after my surgery.

I understand that I am to follow the oral and written instructions given to me, realizing failure to do so
may result in less than optimum results of the procedure and that I am to present myself for post operative
appointments as scheduled. I request the performance of the procedure named above and such additional
procedures as may be found necessary in the judgment of my doctor during the course of this treatment. I
understand unforeseen circumstances may necessitate a change in the desired procedure or in rare cases,
prevent completion of the planned procedure. I request the administration of such anesthesia as may be
considered necessary or advisable in the judgment of the doctor.

Exceptions to surgery or anesthesia, if any, are:__________________________________________

Initial _____
I request the disposal of any tissues or parts, which may be necessary to remove. I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. However, my identity will not be revealed to the general public without my permission. I understand that there may be additional laboratory charges for specimens taken for biopsies and infections. I have been advised of the risks of the planned procedure as noted above the possible risks of non-treatment, and the procedures to be performed. I have the option of seeking additional opinions from other providers if desired. I have read and understand the consent for surgery above and desire to proceed as planned. I acknowledge that no guarantees have been made to me concerning the outcome or results of the surgery or procedure. I have no unanswered questions concerning the proposed treatment.

Please ask your Dr. Shah if you have any questions concerning this consent form.

Signature of Patient __________________________________________________
Date Time__________________________________________________________

Signature of Witness _________________________________________________
Date Time __________________________________________________________
CONSENT FORM FOR SURGICAL TOOTH EXTRACTIONS 
AND RELATED SURGERY

Instructions to Patient: Please take this document home and read it carefully. Note any questions you might have in the area provided in Paragraph 12. Bring this back to our office at your next appointment and the doctor will review it with you before you sign it.

1. My dentist has recommended the following procedures:

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

2. I have been informed of the risks and complications of the recommended oral surgical procedures, anesthesia, and the proposed drugs including, but not limited to, pain, infection, swelling, heavy or prolonged bleeding, discoloration, numbness and tingling of the lip, tongue, chin, gums, cheeks and teeth; pain, numbness and phlebitis (inflammation of a vein) from an intravenous and/or intermuscular injection; injury to and stiffening of the neck and facial muscles; malfunction of the adjacent facial muscles for an indefinite time; change in occlusion or temporomandibular (jaw) joint difficulty; or injury to adjacent teeth or restorations in other teeth, or injury to adjacent soft tissues.

3. I have further been informed of other potential complications including, but not limited to, nausea, vomiting, allergic reaction, bone fractures, bruises, delayed healing, sinus complications, openings from the sinus into the mouth, apparent facial changes, nasal changes, the possibility of secondary surgical procedures, loss of bone and the invested teeth, non-healing of the bony segments, devitalization (nerve damage which may require a root canal) of teeth and relapse.

4. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of this procedure, the associated treatment and procedures, or the postsurgical dental procedures. I am further aware that there is a risk of failure and/or further corrective surgery may be necessary. Such a failure and remedial procedures may involve additional fees being assessed.

5. I agree and understand I am not to have anything to eat for 5 hours before my surgery.

6. I authorize Dr. Shah to perform the recommended dental procedures. I agree to the type of anesthesia that he/she has discussed with me, specifically (local) (IV sedation) or (general). I agree not to operate a motor vehicle or hazardous device for at least twenty-four (24) hours after the procedure or until fully recovered from the effects of the anesthesia or drugs given for my care. I agree not to drive home after my surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

7. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated and I am under general anesthesia or IV sedation, I further authorize and direct Dr. Shah, his/her associates or assistants of his/her choice, to do whatever he/she/they deem necessary and advisable under the circumstances, including the decision not to proceed with the surgical procedure.

8. I agree to cooperate with the post-operative instructions of my dentist, realizing that any deviation from the instructions or lack of cooperation could result in less than optimum result. I further agree that if I do

Initial _____
not follow my dentist's recommendations and advice for post-operative care, my dentist may terminate the dentist-patient relationship, requiring me to seek treatment from another dentist.

9. To my knowledge, I have given an accurate report of my health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other condition relating to my health or any problems experienced with any prior medical, dental or other health care and treatment.

10. The fee for services has been explained to me and is acceptable, and I understand that there is no warranty or guarantee as to the result of this treatment.

11. I realize and understand that the purpose of this document is to evidence the fact that I am knowingly consenting to the oral surgical procedures recommended by my dentist.

12. Questions I have to ask my dentist ________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

13. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION AND INFORMED CONSENT TO THIS PROCEDURE AND THAT ALL OF MY QUESTIONS, IF ANY, HAVE BEEN ANSWERED. I HAVE HAD THE OPPORTUNITY TO TAKE THIS FORM HOME AND REVIEW IT BEFORE SIGNING IT.

__________________________________________________________________

Patient, Parent or Guardian Date

__________________________________________________________________

Dentist Date

__________________________________________________________________

Witness Date

__________________________________________________________________

Witness Date

Initial _____
Diagnosis. After careful oral examination, a review of radiographs and study of dental condition, my dentist advised me that my missing tooth or teeth might be replaced with artificial teeth supported by an implant or implants.

Recommended Treatment. I have been presented with the following options for treatment.

1. No treatment.
2. Limited use of a new partial denture for eating and public appearance.
3. Crown and bridge-work (if possible).
4. Placement of titanium implant fixtures into the existing bone of the jaw, which will be used to support new restorations, fixed bridgework, or a removable denture.

I have selected the option of placement titanium fixtures into the existing bone of the jaw.

I am aware of the benefits and have been informed of the surgical and prosthodontic procedures, and the risks involved.

Surgical Phase of Procedure. I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of the treatment. My gum tissue will be opened to expose the bone. Implants will be placed, by tapping or threading them, into the holes that have been drilled into my jawbone. The implants will have a snugly fit and will be held tightly in place during the healing phase.

The gum and soft tissue will be stitched closed over or around the implants. A periodontal bandage or dressing may be placed. Healing will be allowed to proceed for a period of three to nine months. I understand that dentures usually cannot be worn during the first two weeks of the healing phase.

I further understand that if clinical conditions turn out to be unfavorable for the use of this implant system, or prevent the placement of implants, my dentist will make a professional judgment of the management of the situation. The procedures also may involve supplemental bone graft or other types of grafts to build up the ridge of my jaw, and thereby to assist the placement, closure, and security of my implants. This may also include the placement of bone grafts into the maxillary sinuses to increase the height and width of bone for the appropriate insertion of implants for use as “back” teeth.

After the surgery, there may be temporary pain, swelling, discoloration of the skin, and numbness or altered sensation. If sinus grafts are used, there may be nosebleeds.

Initial _____
Post-Operative Exam- Post-operative examination will be required at regular intervals.

For example:* 

1. First to third day after surgery.
2. First and second week after surgery;
3. Every two or three weeks after surgery for three months.
4. Every six to eight weeks after surgery from the third month until surgical exposure of the implants.

*Certain situations may require more/less frequent visits.

Post-operative examination will include

a) Visual inspection of gingival tissue.

b) Palpation of the fixture for mobility and tenderness.

c) Periodontal tissue evaluation with respect to inflammation.

d) Biopsy of gingival tissue, if indicated.

e) X-rays, if indicated.

Post-Operative Complications. Some problems that may occur: pain around the implant abutment fixture, infection, phobia, or change of mind by the patient. In addition, some tingling and loss of sensation in the area may occur when the implants are placed in the back of the lower jaw. In rare situations, this altered or loss of sensation may be permanent.

Prognosis. While the prognosis is favorable at this time, the results cannot be guaranteed since unforeseen changes in the bone and soft tissue may occur which may require removal of the implant fixture. If an implant fixture does not join properly with the bone, it will be necessary to remove the implant in question. No problems are usually foreseen as a result of this removal. If, on the remote possibility, the entire group of implant fixtures should fail to integrate into the bone, a new attempt can be made on a later date.

Second Surgical Procedure. For implants requiring a second surgical procedure, the overlaying tissues will be opened at the appropriate time, and the stability of the implant will be verified. If the implant appears satisfactory, an attachment will be connected to the implants. Plans and procedures to create an implant crown or appliance (By your general dentist or restorative dentist) can then begin after the gum tissue has healed.
Prosthetic Phase of Procedure. I understand that at this point I will be referred back to my dentist or to a prosthodontist. This phase is just as important as the surgical phase for the long-term success of the oral reconstruction. During this phase, an implant prosthetic devise or crown will be attached to the implant. This procedure should be performed by a person trained in the prosthetic protocol for the root form implant system.

Expected Benefits. The purpose of the dental implants is to allow me to have more functional artificial teeth. The implants provide support, anchorage, and retention for these teeth.

Principal Risks and Complications. I understand that some patients do not respond successfully to dental implants, and, in such cases, the implant may be lost. Implant surgery may not be successful in providing artificial teeth. Because each patient’s condition is unique, long-term success may not occur.

I understand that complications may result from the implant surgery, drugs, and anesthetics. These complications include, but are not limited to, post surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin or gum, jaw joint injuries, or associated muscle spasm, transient, but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum tissue upon healing resulting in elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reaction, injury to teeth, bone fractures, nasal sinus penetrations, delayed healing, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and may be irreversible.

I understand that the design and structure of the prosthetic appliance can be a substantial factor in the success or failure of the implant. I further understand that alterations made on the artificial appliance or the implant can lead to loss of the appliance or implant. This loss would be the sole responsibility of the person making such alterations. I am advised that the connection between the implant and the tissue may fail and that it may become necessary to remove the implant. (If the implant fails in the first year, of the initial implant surgery, there is no charge for the replacement of the implant with a new one, by Dr. Shah). This can happen in the preliminary phase, during the initial integration of the implant to the bone, or at any time thereafter.

Necessary Follow-up Care and Self Care. I understand that it is important for me to continue to see my dentist or prosthodontist. Implants, natural teeth, and appliances have to be maintained daily in a clean, hygienic manner. Implants and appliances must also be examined periodically and may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions given by my Periodontist.

- Initial _____
No warranty or Guarantee. Even though dental implant have a very high success rate, I hear by acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, a Periodontist cannot predict certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss or devitalization of certain teeth, despite the best of care. (If the implant fails with in the first year, of the initial implant surgery, there is no charge for the replacement of the implant with a new one, by Dr. Shah).

Publications of Records. I authorize photos, slides, and x-rays of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

PATIENT CONSENT

I have been fully informed of the nature of dental implant surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available, and the necessity for follow-up care and self care. I have the opportunity to ask any questions or concerns I may have in connection with the treatment. I hereby consent to performance of dental implant surgery as presented to me during my consultation/treatment planning visit(s).

If clinical conditions prevent the placement of dental implants, I defer to my dentist’s judgment on the surgical management of that situation. I also give permission to receive supplemental bone grafts or other types of grafts to build up the ridge of my jaw and thereby to assist in the placement, closure, and security of my implants.

I understand that the fee for my dental implant(s) and surgery does not include the fee for the restorative work.

I certify that I have read and fully understand this document (pages 1-4).

I hereby give consent to Dr. Shah to perform the necessary treatment.

Date_________ Patient signature___________________________________

Witness signature___________________ Dentist signature___________________

Location and Type of Dental Implants: ____________________________________________________________________

__________________________________________________________________________________

Initial _____
CONSENT FORM FOR IMPLANT SURGERY AND ANESTHESIA

Instructions To Patient: Please take this document home and read it carefully. Note any questions you might have in the area provided in Paragraph 15. Bring this back to our office at your next appointment and the doctor will review it with you before signing on page 4.

1. My doctor has explained the various types of implants used in dentistry and I have been informed of the alternatives to implant surgery for replacement of my missing teeth. I have also been informed of the foreseeable risks of those alternatives. I understand what procedures are necessary to accomplish the placement of the implant(s) either on, in, or through the bone, and I understand that the most common types of implants available are subperiosteal (on), endosteal (in), and transosteal (through). The implant type recommended for my specific condition is circled above. I also understand that endosteal implants (more commonly known as root form) generally have the most predictable prognosis. I further understand that subperiosteal implants, if an option for me, are not as widely used as root form implants but will negate the necessity of having the bone grafting and other surgical procedures which would be necessary for the placement of root form implants. I understand that the risk associated with the use of a subperiosteal implant is the failure and loss of the implant which could further reduce the minimal amount of existing bone which I now have, requiring more extensive bone grafting and other surgical procedures at some future time. I also understand that other dental practitioners may not be familiar or experienced in the use of subperiosteal implants, including their placement, maintenance, and treating any problems which might arise involving the subperiosteal implant. I promise to, and accept responsibility for failing to, return to this office for examinations and any recommended treatment, at least every 6 months. My failure to do so, for whatever reason, can jeopardize the clinical success of the implant system. Accordingly, I agree to release and hold my dentist harmless if my implant(s) fail as a result of my not maintaining an ongoing examination and preventive maintenance routine as stated above.

2. I have further been informed that if no treatment is elected to replace the missing teeth or existing dentures, the non-treatment risks include, but are not limited to:

- maintenance of the existing full or partial denture(s) with relines or remakes every three to five years, or as otherwise may be necessary due to slow, but likely, progressive dissolution of the underlying denture-supporting jaw bone;
- any present discomfort or chewing inefficiency with the existing partial or full denture may persist or worsen in time;
- drifting, tilting and/or extrusion of remaining teeth;
- looseness of teeth, periodontal disease (gum -and bone), possibly followed by extraction (s);
- a potential jaw joint problem (TMJ) caused by a deficient, collapsed or otherwise improper bite.

3. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of my implant surgery, the associated treatment and procedures, or the post surgical dental procedures. I am further aware that there is a risk that the implant placement may fail, which might require further corrective surgery associated with the removal. Such a failure and remedial procedures could also involve additional fees being assessed.

4. I understand that implant success is dependent upon a number of variables including, but not limited to: operator experience, individual patient tolerance and health, anatomical variations, my home care of the implant, and habits such as grinding my teeth. I also understand that implants are available in a variety of designs and materials and the choice of implant is determined in the professional judgment of my dentist.

Initial _____
5. I have further been informed of the foreseeable risks and complications of implant surgery, anesthesia and related drugs including, but not limited to: failure of the implant(s), inflammation, swelling, infection, discoloration, numbness (exact extent and duration unknown), inflammation of blood vessels, injury to existing teeth, bone fractures, sinus penetration, delayed healing or allergic reaction to the drugs or medications used. No one has made any promises or given me any guarantees about the outcome of this treatment or these procedures. I understand that these complications can occur even if all dental procedures are done properly.

6. I have been advised that smoking, alcohol or sugar consumption may effect tissue healing and may limit the success of the implant. Because there is no way to accurately predict the gum and the bone healing capabilities of each patient, I know I must follow my dentist's home care instructions and report to my dentist for regular examinations as instructed. I further understand that excellent home care, including brushing, flossing, and the use of any other device recommended by my dentist, is critical to the success of my treatment and my failure to do what I am supposed to do at home will be, at a minimum, a partial cause of implant failure, should that occur. I understand that the more I smoke, the more likely it is that my implant treatment will fail, and I understand and accept that risk.

7. I have also been advised that there is a risk that the implant may break, which may require additional procedures to repair or replace the broken implant.

8. I authorize my dentist to perform dental services for me, including implants and other related surgery such as bone augmentation. I agree to the type of anesthesia that he/she has discussed with me, circled below, and their potential/side effects, specifically (local) (IV sedation) or (general). I agree not to operate a motor vehicle or hazardous device for at least twenty-four (24) hours or more until fully recovered from the effects of the anesthesia or drugs given for my care. My dentist has also discussed the various kinds and types of bone augmentation material, and I have authorized him/her to select the material which he/she believes to be the best choice for my implant treatment.

9. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated and I am under general anesthesia or I.V. sedation, I further authorize and direct my dentist, his/her associates or assistants of his/her choice, to do whatever he/she/they deem necessary and advisable under the circumstances, including the decision not to proceed with the implant procedure(s).

10. I approve any reasonable modifications in design, materials, or surgical procedures, if my dentist, in his/her professional judgment, decides it is in my best interest to do so.

11. To my knowledge, I have given an accurate report of my health history. I have also reported any past allergic or other reactions to drugs, food, insect bites, anesthetics, pollens, dust; blood diseases, gum or skin reactions, abnormal bleeding or any other condition relating to my physical or mental health or any problems experienced with any prior medical, dental or other health care treatment on my medical history questionnaire. I understand that certain mental and/or emotional disorders may contraindicate implant therapy and have therefore expressly circled either YES or NO to indicate whether or not I have had any past treatment or therapy of any kind or type for any mental or emotional condition.

12. I authorize my dentist to make photos, slides, x-rays or any other visual aids of my treatment to be used for the advancement of implant dentistry in any manner my dentist deems appropriate. However, no photographs or other records which identify me will be used without my express written consent.
13. I realize and understand that the purpose of this document is to evidence the fact that I am knowingly consenting to the implant procedures recommended by my dentist.

14. I agree that if I do not follow my dentist's recommendations and advice for postoperative care, my dentist may terminate the dentist-patient relationship, requiring me to seek treatment from another dentist. I realize that post-operative care and maintenance treatment is critical for the ultimate success of dental implants. I accept responsibility for any adverse consequences which result from not following my dentist's advice.

15. Questions I have to ask my dentist:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

16. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION AND INFORMED CONSENT TO IMPLANT PLACEMENT AND SURGERY AND THAT ALL MY QUESTIONS, IF ANY, HAVE BEEN FULLY ANSWERED. I HAVE HAD THE OPPORTUNITY TO TAKE THIS FORM HOME AND REVIEW IT BEFORE SIGNING IT. I UNDERSTAND AND AGREE THAT MY INITIAL ON EACH PAGE ALONG WITH MY SIGNATURE BELOW WILL BE CONSIDERED CONCLUSIVE PROOF THAT I HAVE READ AND UNDERSTAND EVERYTHING CONTAINED IN THIS DOCUMENT AND I HAVE GIVEN MY CONSENT TO PROCEED WITH IMPLANT TREATMENT AND RELATED SURGERY, INCLUDING ANY ANCILLARY BONE GRAFTING PROCEDURES.

_________________________________  _______________________________________
Dentist Signature  Patient Signature

_________________________________  _______________________________________  
Witness Signature  Witness Signature

Parent or Guardian, if Patient is a Minor

Date: ______________
BONE GRAFTING AND BARRIER MEMBRANE CONSENT FORM

For:

I understand that bone grafting and barrier membrane procedures include inherent risks such as, but not limited to the following:

1. **Pain.** Some discomfort is inherent in any oral surgery procedure. Grafting with materials that do not have to be harvested from your body is less painful because they do not require a donor site surgery. If the necessary bone is taken from your chin or wisdom tooth area in the back of your mouth there will be more pain. It can be largely controlled with pain medications.

2. **Infection.** No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile oral environment, for infections to occur postoperatively. At times, these may be a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, professional attention should be received as soon as possible.

3. **Bleeding, bruising, and swelling.** Some moderate bleeding may last several hours. If profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Swelling usually starts to subside after about 48 hours. Bruises may persist for a week or so.

4. **Loss of all or part of the graft.** Success with bone and membrane grafting is high. Nevertheless, it is possible that the graft could fail. A block bone graft taken from somewhere else in your mouth may not adhere or could become infected. Despite meticulous surgery, particulate bone graft materials can migrate out of the surgery site and be lost. A membrane graft could start to dislodge. If so, the doctor should be notified. You compliance is essential to assure success.

5. **Types of graft material.** Some bone graft and membrane material commonly used are derived from human or other mammal sources. These grafts are thoroughly purified by different means to be free from contaminants. Signing this consent form gives your approval for the doctor to use such materials according to his knowledge and clinical judgment for your situation.

6. **Injury to nerves.** This would include injuries causing numbness of the lips; the tongue; any tissues of the mouth; and/or cheeks or face. This numbness which could occur may be of a temporary nature, lasting a few days, a few weeks, a few months, or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.

7. **Sinus involvement.** In some cases, the root tips of upper teeth lie in close proximity to the maxillary sinus. Occasionally, with extractions and/or grafting near the sinus, the sinus can become involved. If this happens, you will need to take special medications. Should sinus penetration occur, it may be necessary to later have the sinus surgically closed.

8. It is your responsibility to seek attention should any undue circumstances occur post-operatively and you should diligently follow any pre-operative and post-operative instructions.

**Informed Consent**

As a patient, I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or

Initial _____
promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Shah and his associates to render any treatments necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Signature of Patient __________________________________________________
Date Time________________________________________________________________

Signature of Witness ______________________________________________________
Date Time __________________________________________________________________

Initial _____
HALCION INFORMATION AND CONSENT FORM

For:

Taking Halcion one hour prior to your dental appointment is an excellent way to minimize or eliminate anxiety that may be associated with going to the dentist. Even though it is safe, effective, and wears off rapidly after the dental visit, you should be aware of some important precautions and considerations.

I. This consent form and the dental treatment consent from should be signed before you take the medication. They are invalid if signed after you take the pills.

2. The onset of Halcion is 15-30 minutes. Do not drive after you have taken the medication. The peak effect occurs between 1-2 hours. After that, it starts wearing off and most people feel back to normal after 6-8 hours. For safety reasons and because people react differently, you should not drive or operate machinery the remainder of the day. Wait until tomorrow.

3. This medication should not be used if:
   - Hypersensitive to benzodiazepines (Valium, Ativan, Versa etc.)
   - You are pregnant or breast feeding
   - You have liver or kidney disease
   - You are taking the medicines nefazodone antidepressant (Serzone); cimetidine (Tagamet, Tagamet HB, Novocimetine, or Peptol); or levodopa (Dopar or Larodopa) for Parkinson's disease. The following substances may prolong the effects of the Halcion: Benedryl; Pheoergn; Calan (verapamil); Cardizem (diltiazem); erythromycin; HIV drugs indinavir and nelfinovir; and alcohol. There may be unusual and dangerous reactions if you are currently taking illegal drugs.

4. Side effects may include: light-headedness, headache, dizziness, visual disturbances, amnesia, and nausea. In some people, oral Halcion may not work as desired.

5. Smokers will probably notice a decrease in the medications ability to achieve desired results.

6. You should not eat heavily prior to your appointment. You may take the medication with a small amount of food such as juice, toast, etc. Taking it with too much food can make absorption into your system unpredictable.

7. Nitrous oxide (laughing gas) may be used in conjunction with the Halcion and local anesthetic.

8. On the way home from the dentist, your seat in the car should be in the reclined position. When at home, lie down with the head slightly elevated. Someone should stay with you for the next several hours because of possible disorientation and possible injury from falling.

I understand these considerations and am willing to abide by the conditions stated above. I have had an opportunity to ask questions and have had them answered to my satisfaction.

Signature of Patient __________________________________________________
Date Time_________________________________________________

Signature of Witness __________________________________________________

Initial _____
IMPLANT PATIENT
INFORMATION AND CONSENT FORM

For:

1. I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand what is necessary to accomplish the placement of the implant under the gum or in the bone.

2. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.

3. I have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.

4. I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, looseness of teeth, followed by necessity of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial uscles, and tired muscles when chewing.

5. My doctor has explained that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the placement of the implant.

6. It has been explained that in some instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.

7. I understand that excessive smoking, alcohol, or sugar may affect gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

8. I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.

9. To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

10. I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of imp dentistry, provided my identity is not revealed.

11. I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment

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pertinent to the success of comprehensive treatment. I also approve any modification in design, materials, or care, if it is felt this is for my best interest.

Signature of Patient ________________________________
Date Time __________________________________________________________________

Signature of Witness _______________________________
Date Time __________________________________________________________________
REQUEST FOR TREATMENT AND CONSENT
“SANDWICH GRAFT OPERATION”
MAXILLARY (UPPER JAW) RIDGE SURGERY WITH BONE REPLACEMENT GRAFTING
AND POSSIBLE PLACEMENT OF IMPLANTS

For:

Dr. Shah has explained to me the various steps involved in my proposed surgery. Alternative treatment plans have been discussed, and I feel comfortable in proceeding with the outlined surgery.

The following are some facts which pertain to my surgery which have been explained to me:
I understand that surgery will be performed to place a bone graft material on top and within the crestal bone of the upper jaw. The bone graft will be “sandwiched” between the existing bone. Dr. Shah has explained how this operation will be performed to my satisfaction. The graft material will consist of a bone substitute material (hydroxylapatite), tissue bank bone or a combination of both. In approximately five to six months, after the graft has partially healed, a second procedure will be done to insert the implants into the upper jaw and the grafted material. In some cases it is possible to insert the implant and graft in the same operation. It is expected that the implants will become stable and act as anchors for fixed or fixed-detachable bridges or partial dentures. This graft is also being placed in an attempt to either change the contour of the bone ridge, make it wider, or make it larger. The graft material consists of small particles. Some of the particles may work loose during the initial healing period. However, this should not influence the success of the surgery and the particles will do no harm if swallowed. Following the graft, it is sometimes necessary to have a second procedure called a vestibuloplasty. This operation provides more tissue to cover the grafted ridge. A custom surgical split may need to be attached to the jaw (using surgical wire, surgical screw or sutures) for 1 to 4 weeks to help keep the synthetic bone graft in place and to form it properly to the jaw bone. The patient’s existing partial denture or full denture can sometimes be modified for this purpose. The surgical technique has been explained to me in detail. I understand that just as in any surgery complications can occur, including; but not limited to, infection, bleeding, tissue damage, permanent numbness of the upper lip, face, or cheeks, and loss of the graft, (requiring futuresurgical procedures).

I have been informed and understand that occasionally there are complications of surgery, drugs, and anesthesia including, but not limited to:

- Pain, swelling and postoperative discoloration of face, neck, and mouth.
- Numbness and tingling of the upper lip, teeth, gums, check and palate, which may be temporary or,
- rarely permanent.
- Infection of the bone that might require further treatment, including hospitalization and surgery.
- Mal-union, delayed union, or non-union of the bone graft replacement material to the normal bone.
- Lack of adequate bone growth into the bone graft replacement material.
- Bleeding which may require extraordinary means to control hemorrhage.
- Limitation of jaw function.
- Stiffness of facial and jaw muscles.
- Injury to the teeth.
- Referred pain to the ear, neck and head.
- Postoperative complications involving the sinuses, nose, nasal cavity, sense of smell, infraorbital regions, and altered sensations of the check and eyes.
- Postoperative unfavorable reactions to drugs, such as nausea, omitting, and allergy.
- Possible loss of teeth and bone segments.

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Although unlikely, it is possible that the graft material will not “take” and not attach to normal bone. The graft may be loose, and the gum tissue may ulcerate over the graft. If this occurs the graft material will need to be removed. Further surgery, including mucosal or skin grafts, may be needed to repair lost mouth tissue. After surgery, there will be certain amount of discomfort and swelling. I understand that I will need to be on a liquid to a very soft diet for two to three weeks.

I agree to keep my teeth and mouth meticulously clean. I also agree to keep all post-operative appointments and check-ups as required by my doctor. I give my permission for Dr. Shah to photograph and video this operation for purposes of education, publishing, and teaching. Knowing the above facts, I freely give my consent to Dr. Shah to perform a synthetic bone graft to my upper jaw.

Signature of Patient _________________________________
Date Time _________________________________

Signature of Witness _________________________________
Date Time _________________________________

Initial ______
ORAL SURGERY AND DENTAL EXTRACTIONS INFORMED CONSENT

For:

I understand that oral surgery and/or dental extractions include inherent risks such as, but not limited to the following:

1. **Injury to the nerves**: This would include injuries causing numbness of the lips; the tongue; any tissues of the mouth and/or cheeks or face. The numbness which could occur may be of a temporary nature, lasting a few days, a few weeks, a few months, or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.

2. **Bleeding, bruising, and swelling**: Some moderate bleeding may last several hours. If profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Swelling usually starts to subside after about 48 hours. Bruises may persist for a week or so.

3. **Dry Socket**: This occurs on occasion when teeth are extracted and is a result of a blood clot not forming properly during the healing process. Dry sockets can be extremely painful if not treated.

4. **Sinus involvement**: In some cases, the root tips of upper teeth lie in close proximity to sinuses. Occasionally during extraction or surgical procedures the sinus membrane may be perforated. Should this occur, it may be necessary to have the sinus surgically closed. Root tips may need to be retrieved from the Sinus.

5. **Infection**: No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile oral environment, for infections to occur postoperatively. At times, these may be a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, professional attention should be received as soon as possible.

6. **Fractured jaw, roots, bone fragments, or instruments**: Although extreme care will be used, the jaw, teeth, roots, bone spicules, or instruments used in the extraction procedure may fracture or be fractured. Requiring retrieval and possibly referral to a specialist. A decision may be made to leave a small piece of root, bone fragment, or instrument in the jaw when removal may require additional extensive surgery, which could cause more harm and add to the risk of complications.

7. **Injury to adjacent teeth or fillings**: This could occur at times no matter how carefully surgical and/or extraction procedures are performed.

8. **Bacterial Endocarditis**: Because of normal existence of bacteria in the oral cavity, the tissues of the heart, as a result of reasons known or unknown, may be susceptible to bacterial infection transmitted through blood vessels, and Bacterial Endocarditis (an infection of the heart) could occur. It is my responsibility to inform the dentist of any heart problems known or suspected.

9. **Unusual reactions to medications given or prescribed**: Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Other methods of contraception must be utilized during the treatment period.

10. It is my responsibility to seek attention should any undue circumstances occur post-operatively and I shall diligently follow any pre-operative and post-operative instructions given to me.

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Informed Consent

As a patient, I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Shah and his associates to render any treatments necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Signature of Patient ________________________________________________
Date Time_______________________________________________________

Signature of Witness ______________________________________________
Date Time ________________________________________________________

Initial _____
PROSHTODONTIC TREATMENT INFORMATION, DISCUSSION OF POTENTIAL RISK AND PROBLEMS AND INFORMED CONSENT

For:

This booklet has been prepared by Dr. Shah to familiarize you with facts about PROSTHETIC TREATMENT. Please read it and write any questions in the margins, so you can discuss them with Dr. Shah.

Please bring this booklet with you to your appointments. Before any treatment is started, you will be asked to sign a statement that you have read and understand this information, and have had the opportunity to have all of your questions answered.

INTRODUCTION:
The following information is routinely discussed with patients considering prosthodontic treatment in our office. While recognizing the benefits of a pleasing smile and well functioning teeth, you should also be aware that prosthodontic treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations seldom contraindicate treatment: however, they should be considered in making your decision to have prosthodontic treatment. Treatment of human biologic conditions will never reach a state of perfection despite technological advancements; problems can occur. This pamphlet is intended to inform you of some of the potential problems of prosthodontic treatment. Many of the problems mentioned occur only occasionally and rarely. There may be other inherent risks not discussed in this brochure. Prosthodontic treatment usually proceeds as planned; however, like all other healing arts, results cannot be guaranteed.

INITIAL DIAGNOSTIC PROCEDURES:
Diagnostic procedures help formulate treatment recommendations. When appropriate, these procedures may include:

- Medical and dental history,
- Physical examination of the mouth and associated structures,
- X-rays,
- Models of the teeth and/or associated structures,
- Photographs
- Conference with previous or current treating health professionals.

Additional diagnostic procedures may be indicated.

TREATMENT RECOMMENDATIONS:
You should be informed of the most appropriate and reasonable alternative treatment plans. Also, you should be informed of the dental prognosis if no prosthodontic treatment is initiated. If you have any questions I encourage you to discuss them with me.

REFERRALS TO OTHER SPECIALISTS:
Sometimes the need for treatment by another dental specialist or health practitioner becomes evident during your prosthodontic treatment. If this need occurs the appropriate referral, and the reasons for the referral will be explained to you.

Initial _____
REMOVABLE PROSTHODONTICS:
Removable prosthodontics is the replacement of missing teeth that can be removed from the mouth. This can be accomplished with several types of dentures. These include; complete removable dentures supported by gum tissues, removable partial dentures supported by gum tissue and remaining teeth and implants, and OVERDENTURES supported by roots of natural teeth or implants.

Potential Problems With Removable Prosthodontics:
Dentures are removable replacements of natural teeth. You should be aware of the following potential problems

1. Mastication (chewing), Stability, and Retention: Removable dentures, under the best of circumstances, do not have the same chewing efficiency as natural teeth. The ability to chew food is further affected by the stability and retention of the dentures. The stability and retention of dentures are depend on many factors, including the attachment to the dentures to natural teeth or implants, the amount and type of bone, gum disease, saliva, your dexterity and the fit of the dentures to your gum tissue or implant support system.

2. Appearance: Proper fitting dentures support the lips and facial contours. Dentures can provide additional facial support if desired or needed. Excessive lip and facial support from dentures can result in a “swollen” appearance.

3. Speech: Removable dentures cover areas of the jaws and palate. The presence of acrylic resin, metal or porcelain in these areas requires adaptation of the tongue and lips for proper speech.

4. Stain and cleaning: The amount of stain on dentures depends on oral hygiene use of tobacco, coffee, and tea. Commercially available denture cleaning solutions are usually sufficient to maintain clean dentures. Bleach should not be used to clean removable dentures. Bleach can corrode the metal portions of the dentures and/or fade the pink acrylic resin. Abrasive kitchen or bathroom cleaners should be avoided

5. Chipping and wear: Porcelain denture teeth have the slowest rate of wear and the highest stain resistance. However, porcelain has a tendency to chip. Small chips can be polished. Larger chips usually require replacement of the porcelain tooth on the denture. Acrylic resin denture teeth are more resistant to chipping, but they have a tendency to wear down faster than porcelain. If the wear affects the appearance or occlusion (bite), the acrylic resin teeth can be replaced on the denture. Chips and cracks of the pink acrylic resin portion can usually be repaired without remaking the denture.

6. Relines: The shape and size of the gum tissue and bone changes with time. A reline procedure readapts the pink acrylic resin portion of the denture to the new shape and size of your gum tissue. A reline is usually necessary every three to five years.

7. Food Retention: Removable dentures always have some space between the pink acrylic resin portion and the gum tissue. There is always some movement of the removable denture during chewing. These factors create a situation where food can accumulate between the denture and the gum tissue. Therefore, it is essential to remove the denture for cleaning on a daily basis. Removable partial dentures may have additional food retention problems.

INFORMED CONSENT AND TREATMENT CONFIRMATION

I certify that this "Prosthodontic Treatment" pamphlet outlining general treatment considerations and potential problems and hazards of prosthodontic treatment was presented to me and that I have read and

Initial _____
understand its contents. I understand that potential hazards and problems may include, but are not limited to, those described in the brochure. I have had the opportunity to discuss my proposed treatment and the potential problems with the doctor to clarify any areas I did not understand. I authorize the doctor to provide prosthodontic treatment.

Signature of Patient __________________________________________________
Date Time_________________________________________________

Signature of Witness __________________________________________________
Date Time ________________________________________________

**IMPLANTS**
I understand that incisions will be made inside my mouth for the purpose of placing one or more titanium or coated titanium implants in my jaw(s). The implants should serve as anchor(s) for a missing tooth or teeth to stabilize a crown, bridge, or denture.
I have been informed that the implant must remain covered, under the gum tissue or at least three months before it can be uncovered. A second surgical procedure is required to uncover the top of the implant. The crown, bridge, or denture and stabilizing bars will be attached to the implant(s) after it is uncovered.

I understand that the implant should last for many years, but that no guarantee that it will last for any specific period of time can be or has been given. It has been explained to me that once the implant is inserted, the entire dental treatment plan, including my personal oral hygiene and prophylaxis, must be followed and completed on schedule or the implant may fail.
The alternatives to an implants, including no treatment, construction of a new standard denture or partial denture, augmentation of the upper or lower jaw, skin or bone grafting have been explained to me. The advantages and disadvantages of each of these procedures has also been discussed and explained to me.

**INFORMED CONSENT AND TREATMENT CONFIRMATION**
I certify that this "Prosthodontic Treatment" pamphlet outlining general treatment considerations and potential problems and hazards of prosthodontic treatment was presented to me and that I have read and understand its contents. I understand that potential hazards and problems may include, but are not limited to, those described in the brochure. I have had the opportunity to discuss my proposed treatment and the potential problems with the doctor to clarify any areas I did not understand. I authorize the doctor to provide prosthodontic treatment.

Signature of Patient __________________________________________________
Date Time_________________________________________________

Signature of Witness __________________________________________________
Date Time ________________________________________________
REQUEST FOR TREATMENT AND CONSENT
SINUS LIFT PROCEDURE WITH BONE REPLACEMENT GRAFTING AND POSSIBLE PLACEMENT

For:

I authorize and request Dr. Shah to perform surgery on my upper jaw (maxilla). I understand that surgery will be performed to place a bone graft material into the floor of the sinus to build up adequate bone height for the placement of implants. The bone graft will consist of a bone substitute material (hydroxylapatite), tissue bank bone or a combination of both. In approximately five to six months, after the graft has partially healed, a second procedure will be done to insert the implant into the upper jaw and the grafted material. In some cases it is possible to insert the implants and graft to the floor of the sinus at the same operation. It is expected that the implants will become stable and act as anchors for fixed or fixed-detachable bridges or dentures.

Dr. Shah has explained that if the new bone does not incorporate into the bone graft material, alternative prosthetic measures will have to be considered. Dr. Shah has explained and described the procedure to my satisfaction. The likelihood for success of the suggested treatment plan is good. However, there are risks involved. The bone graft material has produced good results when placed on top of the upper or lower jaw ridge. However, there are insufficient long-term studies to evaluate placement of the material on the sinus floor. This bone graft replacement material has previously been shown to be free from rejection or infection. There is no guarantee that your graft will not become infected or be rejected. There have been some cases of failure of the graft to incorporate new bone or to sustain implants. Rarely, implants have failed and require removal; occasionally, the area can be regrafted and implants reinserted. It is understood that although good results are expected, they cannot be and are not implied, guaranteed, or warrantable. There is also no guarantee against unsatisfactory or failed results.

I have been informed and understand that occasionally there are complications of surgery, drugs, and anesthesia including, but not limited to:

1. Pain, swelling and postoperative discoloration of face, neck, and mouth.
2. Numbness and tingling of the upper lip, teeth, gums, check and palate, which may be temporary or rarely permanent.
3. Infection of the bone that might require further treatment, including hospitalization and surgery.
4. Mal-union, delayed union, or non-union of the bone graft replacement material to the normal bone.
5. Lack of adequate bone growth into the bone graft replacement material.
6. Bleeding which may require extraordinary means to control hemorrhage.
7. Limitation of jaw function.
8. Stiffness of facial and jaw muscles.
9. Injury to the teeth.
10. Referred pain to the ear, neck and head.
11. Postoperative complications involving the sinuses, nose, nasal cavity, sense of smell, infraorbital regions, and altered sensations of the check and eyes.
12. Postoperative unfavorable reactions to drugs, such as nausea, omitting, and allergy.
13. Possible loss of teeth and bone segments.

I understand that I am not to use alcohol or non-prescribed drugs during the treatment period. Dr. Shah has discussed with me that smoking is particularly harmful to the success of this operation. I have been requested to stop smoking. I understand that Dr. Shah will give his best professional care toward the accomplishment of the desired results. I understand that I can ask for full recital of all possible risks.

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attendant to phases of my care by asking. I have been given a booklet concerning the surgery. I further understand that I am free to withdraw from treatment at any time.

I give permission for persons other than the doctors involved in my care and treatment to observe this operation, and to photograph it for the purposes of teaching and research. I understand this consent form, the booklet, and the personal treatment planning letter. I request Dr. Shah to perform the surgery discussed. I hereby state that I read, speak and understand English.

Signature of Patient __________________________________________________
Date Time_________________________________________________

Signature of Witness _________________________________________________
Date Time ________________________________________________________
PATIENT’S CONSENT FOR CROWN LENGTHENING

For:

DIAGNOSIS: After a careful oral examination and study of my dental condition, my dentist has advised me that tooth decay or a fracture has progressed under the gum level. I understand that with this condition, my dentist will not be able to fabricate a well-fitting crown. In addition, placing a crown or a filling at this stage may create gum diseases and bone loss. This procedure may also be performed in order to improve esthetics; for example, lengthening short teeth in order to improve a "gummy smile," or an uneven gum line.

RECOMMENDED TREATMENT: In order to treat this condition, my dentist has recommended that a crown lengthening procedure be performed to expose some of the tooth structure under the gum level. I understand that sedation may be utilized and that local anesthetics will be administered to me as part of the treatment. This minor surgical procedure involves trimming some of the tissues around the teeth in the area to allow proper restoration of the teeth involved.

EXPECTED BENEFITS: The purpose of crown lengthening is to allow your dentist to restore the involved teeth with a well-fitting crown. This will reduce the likelihood of gum inflammation in the area and will make it easier to clean.

RISKS RELATED TO THE PROCEDURE: Risks related to crown lengthening include but are not limited to post-surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot or cold or sweets or acidic foods, shrinkage of the gum upon healing resulting in elongation of some teeth and greater spaces between some teeth. Risks related to anesthetics might include but are not limited to allergic reactions, accidental swallowing of foreign mater, facial swelling or bruising, pain, soreness or discoloration at the site of injection of the anesthetics.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in treating the present condition. It is anticipated (hoped) that the surgery will provide benefit in exposing additional tooth structure that is necessary for restorative treatment. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition.

CONSENT TO UNFORSEEN CONDITIONS: During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. These may include but are not limited to extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multirooted tooth so as to preserve the tooth, or termination of the procedure prior to completion of all of the surgery originally scheduled. Additional restorative work may need to be done by your dentist. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may effect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth and to the use of prescribed medications. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and so that the doctor can evaluate and report on the outcome of surgery upon the completion.

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SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my identity is not revealed.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after careful consideration, I give my consent for the performance of any and all procedures related to bone grafting/regeneration as presented to me during consultation and treatment plan presentation by the doctor or as described in this document. I certify that I have read this form completely and have had all my questions answered. I understand the above consent to treatment, the explanation therein referred to or made, and that all blanks or statements requiring insertion or completion were filled in and in applicable section, if any, were stricken before I signed. I also understand that this is not a contract of agreement to accept treatment.

Signature of Patient ________________________________
Date Time ________________________________________

Signature of Witness ________________________________
Date Time ________________________________________
PATIENT'S CONSENT FOR GINGIVAL GRAFT SURGERY

For:

EXPLANATION OF DIAGNOSIS: I have been informed of the presence of significant gum recession or insufficient gum tissue in my mouth, which may be adjacent to a muscle attachment. I understand that it is important to have a sufficient amount of firm gum tissue around teeth at the gumline to minimize further gum recession, which may compromise tooth retention.

EXPLANATION OF GINGIVAL GRAFTING: I have been informed that the main purpose of gingival (gum) grafting is to create an adequate zone or band (width) of firm gum tissue to help further prevent gum recession. Graft surgery may also be performed to cover exposed roots.

RECOMMENDED TREATMENT: It has been recommended that gingival grafting be performed in areas of my mouth where I have gum recession. It has been explained that this is a surgical procedure involving the removal of a thin strip of gum tissue from either the surface or beneath the surface of my mouth alongside the upper teeth and transplanted (moved) over to the area of the gum recession or exposed root(s). I understand that some or all of the gum placed over the root may shrink back during healing and that proposed surgical attempt to cover the exposed root surface may not be completely successful. Sometimes this procedure can be accomplished without the removal of tissue from the palate (roof of the mouth).

RISKS RELATED TO THE SUGGESTED TREATMENT: Although a low risk procedure, risks related to gingival grafting might include post-operative bleeding, swelling, pain, infection, facial discoloration, temporary or on occasion permanent tooth sensitivity to hot or cold or sweets or acidic foods. A temporary or permanent numbing of the surgical areas may occur on rare occasion. Risks related to the local anesthetics include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness or discoloration at the site of injection of the local anesthetics.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in treating recessions. It is anticipated (hoped) that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the potential of longer retention of my teeth by reducing the likelihood of further gum recession in the treated area(s) but due to individual patient differences certainty of success is not assured. Therefore, failure, relapse, selective retreatment, or worsening of my present condition may occur.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that smoking and/or alcohol intake may adversely affect gum healing or compromised surgical success. I agree to follow instructions related to my own daily care of my mouth. I agree to attend appointments following my surgery as that healing may be monitored and reevaluated upon healing completion for future needs.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to Photography, filming, recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my identity is not revealed.

PATIENT’S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or

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implied, and that after careful consideration, I give my consent for the performance of any and all procedures related to I.V. conscious sedation as presented to me during consultation and treatment plan presentation by the doctor or as described in this document.

I certify that I have read this form completely and have had all my questions answered. I understand the above consent to treatment, the explanation therein referred to or made, and that all blanks or statements requiring insertion or completion were not filled in and in applicable section, if any, were stricken before I signed. I also understand that this is not a contract of agreement to accept treatment.

Signature of Patient __________________________________________________
Date Time_________________________________________________

Signature of Witness _________________________________________________
Date Time _______________________________________________________

Initial _____
Consent Addendum- Bisphosphonates

Please check if you have taken or been treated with the following drugs for osteoporosis or metastatic bone cancer:

- Etidronate (Didronel)
- Alendronate (Fosamax)
- Pamidronate (Aredia)
- Ibandronate (Boniva)
- Zoledronic acid (Zometa)
- Risedronate (Actonel)
- Fosamax (Alendronate Sodium)
- Boniva (Ibandronate sodium)
- Actonel (Risedronate)
- Pamidronate IV
- Zolendronate IV
- I have been treated for metastatic bone cancer

Any Dental procedures performed including but not limited to extractions, endodontics, orthodontics and any surgical procedure may cause bone and/or infection complications including bone necrosis as a result of these medications.

Signature of Patient __________________________________________________
Date Time_________________________________________________

Signature of Witness ____________________________________________
Date Time __________________________________________________